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1.0 Description of Services

Outpatient specialized therapies include evaluations, re-evaluations, and/or multidisciplinary evaluations as well as therapeutic physical, occupational, speech, respiratory, and audiologic services provided by all provider types and in all settings except hospital/rehabilitation inpatient settings.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

Note: Refer to **Section 5.0** for specific eligibility limitations.

Medicaid-eligible ~~individuals~~recipients with a need for specialized therapy services confirmed by a licensed Medical Doctor, MD, Doctor of Podiatric Medicine, DPM, Doctor of Osteopathic Medicine, DO, Physician Assistant, PA, Nurse Practitioner, NP or Certified Nurse Midwife, CNM are eligible to receive specialized therapies. This policy does not supercede eligibility restrictions or other governing program policies (ex., as in home health, federal regulations allow only a licensed MD or DO to order a service).

Note: Medicare recipients are exempt from this policy.

2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination****** (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

a. that is unsafe, ineffective, or experimental/investigational.
b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

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Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

****EPSDT and Prior Approval Requirements**

a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does NOT eliminate the requirement for prior approval.

b. IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the Basic Medicaid Billing Guide, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

***Basic Medicaid Billing Guide*:** http://www.ncdhhs.gov/dma/medbillcaguide.htm

EPSDT provider page: http://www.ncdhhs.gov/dma/EPSDTprovider.htm

3.0 When the Procedure, Product, or Service Is Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

3.1 General Criteria

Medicaid covers procedures, products, and services related to this policy when they are medically necessary and

a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;

b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and

c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

All ~~services~~outpatient specialized therapies must be medically necessary as defined by the policy guidelines (national standards, best practice guidelines, etc.) recommended by the authoritative bodies for each discipline.

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Medically necessary ~~services~~outpatient specialized therapies are covered for recipients over 21 only when provided by home health providers, hospital outpatient departments, physician offices, and local management entities.

~~**Note:** Any maintenance criteria that the guidelines reference are applicable only to home health providers. Medicaid reimburses maintenance therapies only in the home health setting.~~

3.2.1 Physical Therapy

Medicaid accepts the medical necessity criteria for beginning, continuing, and terminating treatment as published by the American Physical Therapy Association in their most recent edition of *Physical Therapy: Guide to Physical Therapist Practice, Part Two: Preferred Practice Patterns.*

Exception: A specific "treatable" functional impairment that impedes ability to participate in productive activities needs to be identified as the basis for beginning treatment rather than a specific "reversible" functional impairment that impedes ability to participate in productive activities.

~~3.2.2 Home Health Maintenance Physical Therapy~~

~~Maintenance is defined in the *Guide to Physical Therapy Practice*, second edition, Part 1, Chapter 1, under the heading "Episode of Care, Maintenance or Prevention" as "a series of occasional clinical and educational and administrative services related to maintenance of current function."~~

~~Requirements and Limits:~~

~~Information required to be submitted along with the treatment plan for maintenance physical therapy under Home Health:~~

- ~~a. List the skills and/or training required that are different from skills and/or training available from someone other than the therapist.~~
- ~~b. Document the decline in patient function when therapy is decreased or stopped.~~
- ~~c. In addition to the care plan, the therapist must write a time-limited plan for tapering and discontinuing or for limiting therapist involvement. That may be done in one of two ways.~~
  - ~~1. Write a time-limited plan for tapering and discontinuing the maintenance physical therapy services, or~~
  - ~~2. Write a time-limited plan for transferring the therapy services to a non-therapist and changing the role of the therapist to a supervisory role. That role must be consistent with the APTA definition of maintenance.~~

  ~~**Note:** The taper and discontinuation or transfer do not have to occur before the end of the 60 days or less for which prior approval will be given. If the tapering and discontinuation or transfer plan extends beyond the 60-day maximum for prior approval for Home Health maintenance physical therapy, it will be necessary to get approvals every 60 days until the plan is completed.)~~

~~Document attempts to teach maintenance services and techniques to other resource individuals and the results of those attempts no less than every 60 days. Submit with the care plan.~~

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3.2.3 Occupational Therapy

Medicaid accepts the medical necessity criteria for beginning, continuing, and terminating treatment as published by the American Occupational Therapy Association in their most recent edition of *Occupational Therapy Practice Guidelines Series*.

Exception: A specific "treatable" functional impairment that impedes ability to participate in productive activities needs to be identified as the basis for beginning treatment rather than a specific "reversible" functional impairment that impedes ability to participate in productive activities.

~~Home Health Occupational Therapy Maintenance services are not a covered service.~~

3.2.4 Speech/Language-Audiology Therapy

Medicaid accepts the medical necessity criteria for Speech/Language-Audiology therapy treatment as follows:

a. *Basic Elements of Coverage of Speech-Language Pathology and Dysphagia Services* (http://cms.hhs.gov/manuals/pub13/pub_13.asp; Section 3101.10A) and *Special Instructions for Medical Review of Dysphagia Claims* (http://cms.hhs.gov/manuals/108_pim/pim83c06s07.asp#Sect10) have been replaced by CMS with Publication 100-3 Medicare National Coverage Determinations Manual 170.3-Speech Language Pathology Services for the Treatment of Dysphagia (Rev.55, Issued: 05-05-06, Effective :10-01-06, Implementation: 10-2-06) and Publication 100-2 The Medicare Benefit Policy, Chapter 15, Covered Medical and Other Health Services, Sections 220 and 230.3 (Rev 36, Issued:06-24-05, Effective: 06-06-05, Implementation:06-06-05) These publications can be found at http://www.cms.hhs.gov/manuals/IOM/list.asp **and**

b. ASHA guidelines regarding bilingual services (http://www.asha.org) Position Statement *Clinical Management of Communicatively Handicapped Minority Language Populations* **and**

c. The following criteria guidelines are for ~~patients~~recipients ~~ages Birth to~~ under the age of 21 years.

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Language Impairment Classifications Infant/Toddler – Birth to 3 Years	
Mild	• Standard scores 1 to 1.5 standard deviations below the mean, **or** • Scores in the 7^{th} –15^{th} percentile, **or** • A language quotient or standard score of 78 – 85, **or** • A 20% - 24% delay on instruments that determine scores in months, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.
Moderate	• Standard scores 1.5 to 2 standard deviations below the mean, **or** • Scores in the 2^{nd} – 6^{th} percentile, **or** • A language quotient or standard score of 70 – 77, **or** • A 25% - 29% delay on instruments which determine scores in months, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.
Severe	• Standard scores more than 2 standard deviations below the mean, **or** • Scores below the 2^{nd} percentile, **or** • A language quotient or standard score of 69 or lower, **or** • A 30% or more delay on instruments that determine scores in months, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.

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Preschool – Age 3 Years to Kindergarten-Eligible Language Impairment Classifications	
Mild	• Standard scores 1 to 1.5 standard deviations below the mean, **or** • Scores in the 7^{th} – 15^{th} percentile, **or** • A language quotient or standard score of 78 – 85, **or** • If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 6 to 12 month delay, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.
Moderate	• Standard scores 1.5 to 2 standard deviations below the mean, **or** • Scores in the 2^{nd} – 6^{th} percentile, **or** • A language quotient or standard score of 70 – 77, **or** • If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 13 to 18 month delay, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.
Severe	• Standard scores more than 2 standard deviations below the mean, **or** • Scores below the 2^{nd} percentile, **or** • A language quotient or standard score of 69 or lower, **or** • If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 19 month or more delay, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.

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Language Impairment Classifications School Age – Kindergarten-Eligible to Age 21	
Mild	• Standard scores 1 to 1.5 standard deviations below the mean, **or** • Scores in the 7^{th} – 15^{th} percentile, **or** • A language quotient or standard score of 78 –85, **or** • If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrate a 1 year to 1 year, 6 month delay, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics, or pragmatics.
Moderate	• Standard scores 1.5 to 2 standard deviations below the mean, **or** • Scores in the 2^{nd} – 6^{th} percentile, **or** • A language quotient or standard score of 70 – 77, **or** • If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 1 year, 7 month to 2 year delay, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.
Severe	• Standard scores more than 2 standard deviations below the mean, **or** • Scores below the 2^{nd} percentile, **or** • A language quotient or standard score of 69 or lower, **or** • If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 2 year or more delay, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.

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Articulation/Phonology Impairment Classifications All Ages	
Mild	• Standard scores 1 to1.5 standard deviations below the mean, **or** • Scores in the 7^{th} – 15^{th} percentile, **or** • One phonological process that is not developmentally appropriate, with a 20% occurrence, **or** • Additional documentation of examples indicating a delay, such as percent consonant correct measures, measures of intelligibility, tests of stimulability, etc. Child is expected to have few articulation errors, generally characterized by typical substitutions, omissions, and/or distortions. Intelligibility not greatly affected but errors are noticeable.
Moderate	• Standard scores 1.5 to 2 standard deviations below the mean, **or** • Scores in the 2^{nd} – 6^{th} percentile, **or** • Two or more phonological processes that are not developmentally appropriate, with a 20% occurrence, **or** • At least one phonological process that is not developmentally appropriate, with a 21% - 40% occurrence, **or** • Additional documentation of examples indicating a delay, such as percent consonant correct measures, measures of intelligibility, tests of stimulability, etc. Child typically has 3 - 5 sounds in error, which are one year below expected development. Error patterns may be atypical. Intelligibility is affected and conversational speech is occasionally unintelligible.
Severe	• Standard scores more than 2 standard deviations below the mean, **or** • Scores below the 2^{nd} percentile, **or** • Three or more phonological processes that are not developmentally appropriate, with a 20% occurrence, **or** • At least one phonological process that is not developmentally appropriate, with more than 40% occurrence, **or** • Additional documentation of examples indicating a delay, such as percent consonant correct measures, measures of intelligibility, tests of stimulability, etc. Child typically has more than five sounds in error with a combination of error types. Inconsistent errors and lack of stimulability is evident. Conversational speech is generally unintelligible.

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Articulation Treatment Goals Based on Age of Acquisition	
Age of Acquisition	**Treatment Goal(s)**
Before Age 2	Vowel sounds
After Age 2, 0 months	/m/, /n/, /h/, /w/, /p/, /b/
After Age 3, 0 months	/f/, /k/, /g/, /t/, /d/
After Age 4, 0 months	/n/, /j/
After Age 5, 0 months	voiced th, sh, ch, /l/, /v/, j
After Age 6, 0 months	/s/, /r/, /z/, /s/ blends, /r/ blends, vowelized /r/, voiceless th, /l/ blends
In using these guidelines for determining eligibility, total number of errors and intelligibility should be considered. A 90% criterion is roughly in accord with accepted educational and psychometric practice that considers only the lowest 5% - 10% of performances on a standardized instrument to be outside the normal range.	

Phonology Treatment Goals Based on Age of Acquisition of Adult Phonological Rules	
Age of Acquisition	**Treatment Goal(s)**
After age 2 years, 0 months	Syllable reduplication
After age 2 years, 6 months	Backing, deletion of initial consonants, metathesis, labialization, assimilation
After age 3 years, 0 months	Final consonant devoicing, fronting of palatals and velars, final consonant deletion, weak syllable deletion /syllable reduction, stridency deletion/ stopping, prevocalic voicing, epenthesis
When children develop idiosyncratic patterns, which exist after age 3 years, 0 months to 3 years, 5 months, they likely reflect a phonological disorder and should be addressed in therapy. Minor processes, or secondary patterns such as glottal replacement, apicalization and palatalization typically occur in conjunction with other major processes. These minor processes frequently correct on their own as those major processes are being targeted.	
After age 4 years, 0 months	Deaffrication, vowelization/vocalization, cluster reduction, gliding

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Eligibility Guidelines for Stuttering	
Borderline/Mild	3 – 10 sw/m or 3% - 10% stuttered words of words spoken, provided that prolongations are less than 2 seconds and no struggle behaviors and that the number of prolongations does not exceed total whole-word and part-word repetitions.
Moderate	More than 10 sw/m or 10% stuttered words of words spoken, duration of dysfluencies up to 2 seconds; secondary characteristics may be present.
Severe	More than 10 sw/m or 10% stuttered words of words spoken, duration of dysfluencies lasting 3 or more seconds, secondary characteristics are conspicuous.
Note: When the percentage of stuttered words fall in a lower severity rating and duration and/or presence of physical characteristics falls in a higher severity rating, the service delivery may be raised to the higher level.	

Differential Diagnosis for Stuttering

Characteristics of normally dysfluent children:

- Nine dysfluencies or less per every 100 words spoken.
- Majority types of dysfluencies include: whole-word, phrase repetitions, interjections, and revisions.
- No more than two unit repetitions per part-word repetition (e.g., b-b-ball, but not b-b-b ball.).
- Schwa is not perceived (e.g., bee-bee-beet. is common, but not buh-buh-buh-beet).
- Little if any difficulty in starting and sustaining voicing; voicing or airflow between units is generally continuous; dysfluencies are brief and effortless.

The following information may be helpful in monitoring children for fluency disorders. This information indicates dysfluencies that are considered typical in children, crossover behaviors that may be early indicators of true stuttering and what characteristics are typical of true stutterers.

More Usual (Typical Dysfluencies)

- Silent pauses; interjections of sounds, syllables or words; revisions of phrases or sentences; monosyllabic word repetitions or syllable repetitions with relatively even rhythm and stress; three or less repetitions per instance; phrase repetitions.

Crossover Behaviors

- Monosyllabic word repetitions or syllable repetitions with relatively even stress and rhythm but four or more repetitions per instance, monosyllabic word repetitions or syllable repetitions with relatively uneven rhythm and stress with two or more repetitions per instance.

More Unusual (Atypical Dysfluencies)

- Syllable repetitions ending in prolongations; sound, syllable or word prolongations; or prolongations ending in fixed postures of speech mechanism, increased tension noted in the act.

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d. **Augmentative and Alternative Communication** (AAC) standards for treatment from ASHA *Augmentative Communication Strategies*, volume II, 1988:

Note:

a. These criteria define parameters for involvement and services of the therapist for evaluation and treatment, not purchases of the devices or equipment.

b. These criteria are not intended to override or replace existing limits on coverage for services, either as dollar amounts or as acceptable billing codes.

"The primary purpose of an augmentative communication program is to enhance the quality of life for persons with severe speech and language impairments in accordance with each persons preferences, abilities, and life style. Augmentative communication programs perform the continuing, vital, and unique task of helping these individuals develop communication skills they will need throughout the course of their lives. The programs also encourage the development of each individual's initiative, independence, and sense of personal responsibility and self-worth."

AAC treatment programs are developed in accordance with Preferred Practices approved by ASHA. These services include:

a. Counseling

b. Product Dispensing

c. Product Repair/Modification

d. AAC System and/or Device Treatment/Orientation

e. Prosthetic/Adaptive Device Treatment/Orientation

f. Speech/Language Instruction

AAC treatment codes are used for the following:

a. Therapeutic intervention for device programming and development

b. Intervention with family members/caregivers/support workers, and individual for functional use of the device

c. Therapeutic intervention with the individual in discourse with communication partner using his/her device

The above areas of treatment need to be performed by a licensed Speech-Language Pathologist with education and experience in augmentative communication to provide therapeutic intervention to help individuals communicate effectively using their device in all areas pertinent to the individual. Treatment will be authorized when the results of an authorized AAC assessment recommend either a low-tech or a high-tech system.

~~Any time the individual's communication needs change for medical reasons, additional treatment sessions should be requested. In addition, if an individual's device no longer meets his/her communication needs, additional treatment sessions should be requested.~~

Possible reasons ~~to request authorization~~ for additional treatment include:

a. Update of device

b. Replacement of current device

c. Significant revisions to the device and/or vocabulary

d. Medical changes

3.2.5 Audiology Therapy (Aural Rehabilitation) Practice Guidelines

The basis for audiology referral is the presence of any degree or type of hearing loss on the basis of the results of an audiologic (aural) rehabilitation assessment or presence of impaired or compromised auditory processing abilities on the basis of the results of a central auditory test battery.

Examples of deficits for initiating therapy may include, **but are not limited to**, the following:

a. Hearing loss (any type) >25 dBHL at 2 or more frequencies in either ear

b. Standard Score more than 1 SD (standard deviation) below normal for chronological age on standardized tests of language, audition, speech, or auditory processing

c. Impaired or compromised auditory processing abilities as documented on the basis of the results of a central auditory test battery

d. Less than 1-year gain in skills (auditory, language, speech, processing) during a 12-month period of time

Underlying Referral Premise

Aural rehabilitation will:

a. facilitate receptive and expressive communication of ~~individuals~~recipients with hearing loss, and/or

b. achieve improved, augmented or compensated communication processes, and/or

c. improve auditory processing, listening, spoken language processing, overall communication process, and/or

d. benefit learning and daily activities.

Evaluation—Audiologic (Aural) Rehabilitation

Service delivery requires the following elements:

Note: Functioning of hearing aids, assistive listening systems/devices, and sensory aids must be checked prior to the assessment.

Through interview, observation, and clinical testing, evaluate (in both clinical and natural environments):

a. Client history

b. Reception, comprehension, and production of language in oral, signed or written modalities

c. Speech and voice production

d. Perception of speech and non-speech stimuli in multiple modalities

e. Listening skills

f. Speechreading

g. Communication strategies

Include the ICD-9-CM diagnosis code. Determine specific functional limitation(s) (must be measurable) for client.

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Evaluation—Central Auditory Processing Disorders (CAPD)

Note: CAPD assessment is to be interdisciplinary (involving audiologist, speech/language pathologist, and neuropsychologist) and is to include tests to evaluate the overall communication behavior, including spoken language processing and production, and educational achievement of individuals.

Through interview, observation, and clinical testing, evaluate:

a. Communication, medical, educational history.
b. Central auditory behavioral tests. Types of central auditory behavioral tests include:
    1. Tests of temporal processes
    2. Tests of dichotic listening
    3. Low redundancy monaural speech tests
    4. Tests of binaural interaction
c. Central auditory electrophysiologic tests include:
    1. Auditory brainstem response (ABR)
    2. Middle latency evoked response (MLR)
    3. N1 and P2 (late potentials) responses and P300
    4. Mismatched negativity (MMN)
    5. Middle ear reflex
    6. Crossed suppression of otoacoustic emissions

Interpretations are derived from multiple tests based on age-appropriate norms. Evaluation may involve a series of tests given over a period of time at one or more clinic appointments. Procedures in a CAPD battery should be viewed as separate entities for purposes of service provision and reimbursement.

Include the ICD-9-CM diagnosis code. Determine specific functional limitation(s) (must be measurable) for client.

Examples of Functional Deficits

Examples of functional deficits may include, **but are not limited to**, the following:

a. Inability to hear normal conversational speech
b. Inability to hear conversation via the telephone
c. Inability to identify, by hearing, environmental sounds necessary for safety (i.e., siren, car horn, doorbell, baby crying, etc.)
d. Inability to understand conversational speech (in person or via telephone)
e. Inability to hear and/or understand teacher in classroom setting
f. Inability to hear and/or understand classmates during class discussion
g. Inability to hear/understand co-workers/supervisors during meetings at work

h. Inability to read on grade level (as result of auditory processing difficulty)

i. Inability to localize sound

Treatment Planning

The treatment plan is developed in conjunction with client/caregiver and medical provider and considers performance in both clinical and natural environments. Treatment should be culturally appropriate. Short- and long-term functional communication goals and specific objectives are determined from assessment. The amount of time, place(s), and professional or lay person(s) involved must be designated. Generalization of skills and strategies is enhanced by extending practice to the natural environment through collaboration among key professionals. Goals and objectives are reviewed periodically to determine appropriateness and relevance.

a. Short-term Goals: Improve the overall communication process as defined in functional limitations.

b. Long-term Goals: Decrease or eliminate functional deficit.

Note: Rate of improvement varies by client, depending on the severity level, compliance with therapy, and the context in which the client lives and performs activities of daily living.

Discharge/Follow-up

Discharge

The therapy will be discontinued when one of the following criteria is met:

a. ~~Client~~Recipient has achieved functional goals and outcomes.

b. ~~Client's~~Recipient's performance is ~~WNL~~within normal limits for chronological age on standardized measures of language, speech, audition, and/or auditory processing (as applicable to the client).

c. ~~Client~~Recipient/parent is non-compliant with treatment plan.

At discharge, audiologist will identify indicators for potential follow-up care.

Follow-Up

Readmittance to audiologic (aural) rehabilitation may result from changes in functional status, living situation, school or child care, caregiver, or personal interests.

~~**Home Health Speech/Language Maintenance Services**~~

~~Refer to Home Health section of the *N.C. Medicaid Community Care Manual* for limitations.~~

3.2.6 Respiratory Therapy

Medicaid accepts the following medical necessity criteria for respiratory therapy treatment provided through the ~~IP~~Independent Practitioner Program (IPP) to Medicaid recipients ~~ages birth to~~under the age of 21 years.

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Asthma Guidelines	
Level I—Assessment Stage 1 (Mild Intermittent)	• Symptoms ≤ 2 times a week • Nighttime symptoms ≤ 2 times a month • Exacerbations brief (few hours to a few days); intensity may vary • PEF ≥ 80% predicted, PEF variability < 20%
Level II—Assessment and Treatment Stage 2 (Mild Persistent)	• Symptoms > 2 times a week but < 1 time a day • Nighttime symptoms > 2 times a month • Exacerbations may affect activity • PEF ≥ 80% predicted, PEF variability 20% to 30%
Level III—Assessment and Treatment Stage 3 (Moderate Persistent)	• Daily symptoms • Nighttime symptoms > 2 times a month • Daily use of inhaled short-acting $beta_2$-agonist • Exacerbations affect activity • Exacerbations ≥ 2 times a week; may last days • PEF < 80% predicted, PEF variability > 30%
Level IV—Assessment and Treatment Stage 4 (Severe Persistent)	• Continual symptoms • Frequent nighttime symptoms • Limited physical activity • Frequent exacerbations • PEF < 60% predicted: PEF variability > 30%

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Service delivery requires the following elements:

Evaluation
Evaluate the following through interview, observation, and clinical testing: • Client's history of episodic symptoms • Physical assessment (HR, RR, BBS) • Oximetry • PEF measurement • Medication/treatment compliance • Inhaler technique • Lifestyle (e.g., days missed from school or day care and limitations to normal activities • Client–provider communication and client satisfaction Evaluation outcomes should include: • ICD-9-CM code • Specific functional limitation(s), which must be measurable and quantified Examples include but are not limited to: • Respiratory symptoms $\geq$ 2 times a week • Reduction in usual activities $\geq$ 2 times in 1 month due to respiratory symptoms • Respiratory symptoms disturbing sleep $\geq$ 2 times in one month • More than 5 days missed from school in a six-month period related to respiratory symptoms • More than one hospital or ER admissions due to respiratory symptoms in a six-month period

Care Plan
Characteristics of the Care Plan include: • Development with the client/family and medical provider to determine severity level and pharmacological treatment • Short-term goals: e.g., improve respiratory status as defined in functional limitations • Long-term goals: e.g., decrease or eliminate functional deficit

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Discharge/Follow-up
Discharge Therapy will be discontinued when one of the following criteria is met: ● Client has achieved functional goals and outcomes ● Client is able to follow prescribed therapy program independently or with assistance ● A physician orders discharge ● Client reaches age 21 ● Client/parent are non-compliant with treatment plan **Follow-up** At discharge, the respiratory therapist should identify indicators for potential follow-up care such as changes in functional status, living situation, school or childcare, or caregiver.

Chronic Respiratory Guidelines, excluding Asthma	
Level 1—Assessment	● Occasional day and/or night symptoms ● Ability to clear secretions ● Ability to clear breath sounds ● Mildly limited physical activity or bedridden
Level II—Assessment and Treatment	● Daily and nightly symptoms ● Ability to clear secretions ● Ability to clear breath sounds ● Limited physical activity or bedridden
Level III—Assessment and Treatment	● Daily and nightly symptoms ● On-going use of inhaled short-acting $beta_2$-agonist ● Exacerbations affect activity ● Exacerbations $\geq$ 2 times a week; may last days
Level IV—Assessment and Treatment	● Continual symptoms ● Daily and nightly symptoms ● Limited physical activity/bedridden/house-confined ● Frequent exacerbations

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Service delivery requires the following elements:

Evaluation
Evaluate the following through interview, observation, and clinical testing: • Client's history • Physical assessment (HR, RR, BBS) • Pulmonary assessment • Oximetry • PFT (if applicable) • ABG (if applicable) • Radiological findings Evaluation outcomes should include: • ICD-9-CM code • Specific functional limitation(s), which must be measurable and quantified Examples include but are not limited to: • Inability to remove secretions by means of spontaneous cough/ suctioning technique • PFTs below acceptable levels for 2 weeks • Inability to clean and maintain tracheostomy • Inability to maintain O_2 saturation at 94% or better • Unable to exert without shortness of breath • Unable to perform purse-lip and diaphragmatic breathing • Unable to wean from mechanical life support

Care Plan
Characteristics of the Care Plan include: • Development with the client/family and medical provider to determine treatment goals and outcomes • Short-term goals: e.g., improve respiratory status as defined in functional limitations • Long-term goals: e.g., decrease or eliminate functional deficit

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Discharge/Follow-up
Discharge Therapy will be discontinued when one of the following criteria is met: ● Client has achieved functional goals and outcomes ● Client/family is able to follow prescribed therapy program independently or with assistance ● A physician orders discharge ● Client reaches age 21 ● Client/family are non-compliant with treatment plan **Follow-up** At discharge, the respiratory therapist should identify indicators for potential follow-up care such as changes in functional status, living situation, school or childcare, or caregiver.

4.0 When the Procedure, Product, or Service Is Not Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

e. the recipient does not meet the eligibility requirements listed in **Section 2.0;**

f. the recipient does not meet the medical necessity criteria listed in **Section 3.0;**

g. the procedure, product, or service unnecessarily duplicates that of another provider; or

h. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria

Outpatient specialized therapies are not covered when the ~~following~~ policy guidelines are not met.

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5.0 Requirements for and Limitations on Coverage

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

~~5.1 Patient's Location~~

~~A patient may receive specialized therapy in the setting allowed by the provider's type and specialty.~~

5.2 Treatment Services

The ~~initial~~ process for providing treatment, regardless of place of service, consists of the following steps and requirements:

a. All services must be provided according to a written plan.

b. The written plan for services must include defined goals for each therapeutic discipline.

c. Each plan must include a specific content, frequency, and length of visits of services for each therapeutic discipline.

d. A verbal or a written order must be obtained for services***** prior to the start of the services. Backdating is not allowed.

*(*****Services are all therapeutic PT/OT/ST/RT activities **beyond** the entry evaluations. This includes recommendations for specific programs, providers, methods, settings, frequency, and length of visits.)*

e. Service providers must review and renew or revise plans and goals no less often than every six months, to include obtaining another dated physician signature for the renewed or revised orders. There will be no payment for services rendered more than 6 months after the most recent physician order signature date and before the following renewal/revision signature date. The signature date must be the date the physician signs the order. Backdating is not allowed.

LEAs may review, renew and revise the IEP annually, including obtaining a dated physician order and signature, provided that the IEP requirement of parent notification occurs at regular intervals throughout the year, and such notification details how progress is sufficient to enable the child to achieve the IEP goals by the end of the year.

~~f. Up to six unmanaged visits per discipline, per provider type are allowed without prior approval. Evaluations, re-evaluations, and/or multidisciplinary evaluations are not counted in the six unmanaged visits. If six therapy visits occur before six months from a physician's order for any specific discipline, and if services need to~~

~~be continued for additional visits, The Carolinas Center for Medical Excellence (CCME) may approve continued services without an additional physician order under the following conditions:**~~

1. ~~The continued services must have a written plan with defined goals for each therapeutic discipline.~~
2. ~~The written plan must include a specific content, duration, frequency, and length of visits for each therapeutic discipline (e.g., PT services to include [list treatment modalities] for six weeks at three visits per week for 30 minutes each visit).~~
3. ~~The request for continuation of services must be accompanied by the documentation of the plan, goals and outcomes for the previous service interval with progress documented.~~
4. ~~There will be no payment for services rendered in excess of six visits and before the date of the approval for continuation of services.~~

g. ~~If a patient between birth and three years of age has had a CDSA evaluation or a CDSA-approved evaluation and has an Individualized Family Service Plan (IFSP) prior approval is not needed for 6 months after the initial physician's order. CDSAs may do evaluations or approve evaluations between the ages of three and four if children are transitioning and those children would have an Individualized Education Plan (IEP). The initial claim and the request for continued services must both include the date of the physician's order in block 15 on the CMS-1500 (HCFA-1500) claim form. If the date is not included, the claim is subject to the same 6-visit approval requirement as all other claims. Once a provider starts on the 6-visit path it cannot and will not be changed to the 6-month path.~~

h. Faxed orders and faxed signatures are permissible and serve the same purposes for documentation as an original signature on an original form or orders sheet.

5.3 ~~Prior Approval Process~~ Recipients under the Age of 21 Years

After 52 visits per recipient, per discipline, in a 6-month period starting in January of each year (January 1–June 30 and July 1–December 31), ~~six unmanaged visits or six months' prior approval exemption,~~ ~~prior~~ approval is required for continued treatment. Submit a request to DMA or DMA vendor to start the approval process. Please note that ~~prior~~ approval, if granted, is for medical approval only and does not guarantee payment or ensure recipient eligibility on the date of service.~~Please refer to the CCME Web site (https://www2.mrnc.org/priorauth/pages/Home.aspx) for information about the electronic process and forms.~~

~~A prior approval request must be faxed or electronically submitted to CCME for treatment to be continued. If appropriate, CCME will authorize services for a specific number of units through a specific length of time. Units should be requested based on the CPT code billed. If the CPT code is billed by event then 1 unit should be requested. If the CPT code is billed in 15-minute increments with 15 minutes equaling 1 unit, then the number of units to be provided should be requested. Once these limits have been reached, prior approval must again be requested for continued treatment.~~

~~Medicaid's initial authorization for duration of treatment cannot exceed the lowest of the following ranges with a cap of 52 visits during a 6-month time period.~~

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5.4 Visit Limitations for Adults

Outpatient specialized therapies are covered for recipients over 21 only when provided by home health providers, hospital outpatient departments, physician offices, and local management entities.

A recipient 21 years of age or older may have up to 30 combined visits of all therapy treatment visits (PT, OT, SLP) per calendar year, from all therapy providers, in any outpatient setting. Additional visits may be granted to recipients diagnosed with stroke, traumatic brain injury, or spinal cord injury. Additional visits may also be granted to recipients who have a complex diagnosis in combination with a moderate or severe risk assessment score as determined by the physician. These cases will be reviewed on a case-by-case basis. Evaluations and re-evaluations are not treatment visits and are not subject to the service limitations. Therapy services solely for maintenance are not covered.

Note: Home Health: Physician referral, orders, plan of care, and documentation must adhere to Medicare and Medicaid guidelines as outlined in Clinical Coverage Policy 3A, *Home Health Services.* The service must also be in accordance with all other Home Health program guidelines, including the appropriateness of providing service in the home. The policy can be found on DMA's Web site, http://www.ncdhhs.gov/dma/mp/mpindex.htm.

5.5 Medical Necessity Visit Guidelines for All Recipients

5.5.1 Physical and Occupational Therapy

a. The maximum of the usual range of visits for a condition as published in the most recent edition of *Physical Therapy: Guide to Physical Therapist Practice, Part Two: Preferred Practice Patterns* or *Occupational Therapy Practice Guidelines Series*, **or**

b. the number of medically necessary visits ~~requested by the therapist~~, not to exceed a time limit of 6 months.

~~c. Maintenance physical therapy provided under Home Health will be approved at a frequency that does not exceed the 60 day prorated portion of the expected range for the number of visits defined by the appropriate practice pattern in part 2 of the APTA guidelines.~~

~~**Example:** If a practice pattern contains a range of 6 to 96 visits with a frequency of 2 times per week, the prior approval limit will in no case exceed 52 visits over a 6 month period. Using that as the maximum, maintenance physical therapy under Home Health will not be approved for more than (60/183) X 52 = 17 visits, or for more than twice per week.~~

5.5.2 Speech/Language-Audiology Therapy

a. for a recipient with:

1. Mild Impairment range of visits: 6–26
2. Moderate Impairment range of visits: Up to 46
3. Severe Impairment range of visits: Up to 52,

or

b. the number of visits ~~requested by the therapist~~, not to exceed a time limit of 6 months

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c. Audiology: 30- to 60-minute sessions, 1 to 3 times a week, in increments of 6 months ~~(up to 52 visits)~~. Length of visit and duration are determined by the client's level of severity and rate of change.

5.5.3 Respiratory Therapy

Functional performance measures and potential for change determine whether the intervention is needed and the frequency with which it will be provided. Length of visit and duration are determined by the client's level of severity and rate of change.

Asthma Guidelines:

Level I—Stage 1 (Mild Intermittent)
Average Time: 30 – 60 minutes face-to-face with client
Maximum Units: 0

Level II—Stage 2 (Mild Persistent)
Average Time: 30 – 60 minutes face-to-face with client
Average Days: 2 days per week
Average Procedures: 3 procedures
Maximum Units: 156

Level III—Stage 3 (Moderate Persistent)
Average Time: 30 – 60 minutes face-to-face with client
Average Days: 3 days per week
Average Procedures: 3 procedures
Maximum Units: 234

Level IV—Stage 4
Average Time: 30 – 90 minutes face-to-face with client
Average Days: 3 days per week
Average Procedures: 3 procedures
Maximum Units: 234

Chronic Respiratory Guidelines:

Level I
Average Time: 60 minutes face-to-face with client
Maximum Units: 0

Level II
Average Time: 60 minutes face-to-face with client
Average Days: 2 days per week
Average Procedures: 3 procedures
Maximum Units: 156

Level III
Average Time: 60 minutes face-to-face with client
Average Days: 3 days per week
Average Procedures: 4 procedures
Maximum Units: 312

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Level IV
Average Time: 60 – 90 minutes face-to-face with client
Average Days: 5 days per week
Average Procedures: 6 procedures
Maximum Units: 780

Note: Medicare recipients are exempt from this policy.
~~**No more than 52 visits in a 6-month period will be allowed without reauthorization.**~~

~~**For local educational agencies (LEAs) the prior approval process is deemed met by the IEP process; however, all of the requirements listed in Section 7.0, Additional Requirements, below, must be followed.**~~

~~a. If a recipient has had a CDSA evaluation, prior approval is not required for the first six months as long as the recipient has not started on the six-visit path. Refer to item #7, Section 5.2, Treatment Services, for information on CDSA evaluations.~~

~~b. Medicare recipients are exempt from the prior approval process.~~

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

Providers who meet Medicaid's qualifications for participation and are currently enrolled with the N.C. Medicaid program are eligible to bill for procedures, products, and services related to this policy when the procedures, products, or services are within the scope of their practice.

Eligible providers are defined by the following program types. Medicaid-enrolled local education agencies, independent practitioners, home health agencies, children's developmental service agencies, health departments, federally qualified health centers, rural health clinics, hospital outpatient services, and physician offices who employ qualified physical therapists, occupational therapists, respiratory therapists, speech pathologists, or audiologists are eligible to bill for these services. ~~It is responsibility of the provider agency to verify in writing that staff meet the qualifications listed in 42 CFR 440.110 and 440.185.~~ Physical therapists, occupational therapists, speech–language pathologists, and audiologists must meet the qualifications according to 42 CFR 440.110. Respiratory therapists must follow 42 CFR 440.185. ~~A copy of this verification (current licensure or registration) must be maintained by the provider agency.~~ The provider agency is to verify that their staff are licensed by the appropriate body and that the license is current, active, and unrestricted to practice.

7.0 Additional Requirements

7.1 Compliance

Providers must comply with all applicable federal, state, and local laws and regulations, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

7.2 Documenting Services

Each provider must maintain and allow DMA to access the following documentation for each individual:

a. The ~~patient~~recipient name and Medicaid identification number.

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b. A copy of the treatment plan (IEP accepted for LEAs).

c. A copy of the MD, DO, DPM, CNM, PA, or NP's order for treatment services. Home Health services may only be ordered by an MD or DO.

d. Description of services (intervention and outcome/client response) performed and dates of service.

e. The duration of service (i.e., length of assessment and/or treatment session **in minutes**).

f. The signature of the person providing each service.

g. A copy of each test performed or a summary listing all test results, and the written evaluation report.

h. Any other documentation relating to the financial, medical, or other records necessary to fully disclose the nature and extent of services billed to Medicaid.

~~i. A copy of the completed prior approval form with the prior approval authorization.~~

7.3 ~~Utilization~~Post-Payment Validation Reviews

Medicaid ~~or CCME~~ or agents acting on behalf of Medicaid will~~may~~ perform reviews for monitoring utilization, quality, and appropriateness of all services rendered. Post-payment validation reviews will be conducted using a statistically valid random sample from paid claims. Overpayments will be determined using monthly paid claims data. Written notice of the finding(s) will be sent to the specialized therapy provider who is the subject of the review and will state the basis of the finding(s), the amount of the overpayment, and the provider's appeal rights. Case reviews may also show the need for an educational notification to the provider.~~These reviews may include but are not limited to:~~

~~a. Focused reviews of established criteria for service provision.~~

~~b. Reviews of prior approved services.~~

c. ~~Post payment reviews.~~

[Former Section 8.0, Billing Guidelines, has been moved to Attachment A]

8.0 Policy Implementation/Revision Information

Original Effective Date: October 1, 2002

Revision Information:

Date	Section Revised	Change
02/26/03	5.2, Treatment Services, item #4 7.0, Documenting Services, 3rd bullet	Deleted text pertaining to verbal orders; effective with date of policy publication 10/01/02.
04/01/03	5.2, Treatment Services, item #3 5.2, Treatment Services, item #4	The phrase "intensity of services" revised to "length of visits."
04/01/03	5.3, Prior Approval	Prior approval criteria added for physical therapy, occupational therapy, and speech/language therapy.

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Date	Section Revised	Change
04/01/03	3.0, When the Service Is Covered	Coverage criteria added for physical therapy, occupational therapy, and speech/language therapy.
06/01/03	5.2, Treatment Services, item #7	Text was revised to conform with billing guidelines; effective with date of publication 10/01/02.
06/01/03	8.0, Billing Guidelines	Addition of V code diagnosis for treatment services.
07/01/03	3.4, Respiratory Therapy	Medical necessity criteria added for respiratory therapy.
07/01/03	5.3, Prior Approval Process	Respiratory therapy guidelines were added.
07/01/03	8.0, Billing Guidelines	Diagnosis code V57.2 was corrected to V57.21, effective with date of change 06/01/03
10/01/03	Section 3.1.1, Home Health Maintenance Physical Therapy	Criteria was added for Home Health Maintenance Physical Therapy.
10/01/03	Section 3.2, Occupational Therapy	A statement was to added to indicate that Home Health Maintenance Occupational Therapy was not covered.
10/01/03	Section 3.3, Speech/Language-Audiology Therapy	This section was expanded to include Audiology Therapy; the title of the section was changed to Speech/Language-Audiology Therapy. Augmentative and Alternative Communication (AAC) standards for treatment were also added.
10/01/03	Section 3.3.1, Audiology Therapy (aural rehabilitation) Practice Guidelines	Section 3.3.1 was added to address audiology therapy practice guidelines.
10/01/03	Section 5.3.1, item c, Physical and Occupational Therapy	Item c was added to address prior approval for physical therapy maintenance.
10/01/03	Section 5.3.2, item c, Speech/Language-Audiology Therapy	Item c was added to address prior approval for audiology.
12/01/03	Section 5.0	The section was renamed from Policy Guidelines to Requirements for and Limitations on Coverage.
7/01/04	Section 5.2, Treatment Services	Added requirement for LEAs for annual review and order provided that parent notification occurs regularly and details how goals will be attained by year-end.
9/1/05	Section 2.0	A special provision related to EPSDT was added.
12/1/05	Section 2.2	The Web address for DMA's EDPST policy instructions was added to this section.

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Date	Section Revised	Change
1/1/06	Section 5.2 and 7.2	These sections were updated to reflect MRNC's name change to The Carolinas Center for Medical Excellence (CCME).
12/1/06	Section 2.2	The special provision related to EPSDT was revised.
12/1/06	Section 3.0, 4.0, and 5.0	A note regarding EPSDT was added to these sections.
3/1/07	Section 3.0	A reference was added to indicate that medical necessity is defined by the policy guidelines recommended by the authoritative bodies for each discipline.
3/1/07	Section 3.3	A reference to ASHA guidelines regarding bilingual services was added as a source of medical necessity criteria for Speech/Language-Audiology therapy treatment for Spanish speaking recipients
3/1/07	Section 5.2	Item 6.c. was updated to indicate that a request submitted for continuation of service must include documentation of the recipient's progress. Item 7 was corrected to comply with federal regulations. The note at the end of the section was deleted from the policy.
3/1/07	Section 5.3	This section was updated to indicate that prior approval is required after six unmanaged visits or the end of the six-month period. A reference was also added to indicate the prior approval requests may be submitted electronically.
3/1/07	Section 6.0	A reference to 42 CFR 440.110 and 440.185 was added to this section.
3/1/07	Section 7.1	Item 3 Physicians order clarified
3/1/07	Section 8.0	A reminder was added to this section to clarify that prior approval must be requested using the billing provider number and that services initiated through a CDSA are exempt from the prior approval requirement for six months and must, therefore, enter the date of the physician's order on the claim form.
5/1/07	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age.
5/1/07	Section 8	Added UB-04 as an accepted claims form.
	Section 2.1	Moved first paragraph ("recipients with a need for specialized therapy services") to follow standard statement.
	Section 2.2	Added legal citation for EPSDT.

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Date	Section Revised	Change
	Sections 3.0, 4.0, & 6.0	Updated section titles to standard phrasing.
	Section 3.1	Added standard section.
	Section 3.2	Added title to existing criteria; changed "services" to "outpatient specialized therapies"; deleted Note on home health maintenance.
	Section 3.2.2 (was 3.1.1)	Deleted this section on home health maintenance physical therapy.
	Sections 3.2.3 and 3.2.5	Deleted mentions of home health maintenance occupational and audiology therapy.
	Section 3.2.4 (was 3.3), letter c	Changed the word "patients" to "recipients" and rephrased.
	Section 3.2.5	In "Underlying Referral Premise," letter a, changed "individuals" to "recipients." In "Discharge/Follow-up," changed "client" to "recipient"; spelled out "within normal limits."
	Section 3.2.6	Spelled out first appearance of IPP (Independent Practitioner Program); corrected age range.
	Section 4.1	Added standard section.
	Section 4.2	Added title to existing criteria; added the word "outpatient" before the phrase "specialized therapies"; deleted the word "following" from "policy guidelines."
	Section 5.1	Moved this statement to Attachment A, letter F.
	Section 5.2	Deleted the word "initial" from the introductory statement. Deleted letters f and g (information about 6 unmanaged visits vs. 6 months of service; information about evaluation and prior approval by Children's Developmental Services Agency).
	Section 5.3	Changed section title to "Recipients under the Age of 21 Years"; deleted The Carolinas Center for Medical Excellence; changed criteria from 6 visits or 6 months to 52 visits in 6 months; deleted paragraph on Medicaid's initial authorization; added instructions on requesting approval for additional visits.
	Section 5.4	Added new section on visit limitations for adults.
	Section 5.5	Added section title.
	Section 5.5.1	Deleted information on home health maintenance physical therapy; added "medically necessary" before the word "visits"; deleted "requested by the therapist."

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Date	Section Revised	Change
	Section 5.5.2	Deleted reference to 52 visits; deleted "requested by the therapist."
	Section 5.5.3	Deleted 52-visit cap in this location; deleted paragraph that LEAs meet requirement by IEP process; deleted note that prior approval is not required for recipients with a CDSA evaluation; changed "Medicare recipients are exempt from the prior approval process" to "Medicare recipients are exempt from this policy."
	Section 6.0	Added standard paragraph about providers; updated and clarified language.
	Section 7.1	Added standard statement about compliance and renumbered subsequent headings.
	Section 7.2 (was 7.1)	Added DO and DPM as providers who may issue orders; changed "patient" to "recipient"; deleted requirement to keep copy of prior approval form.
	Section 7.3 (was 7.2)	Changed title from "Utilization Reviews" to "Post-Payment Validation Reviews"; deleted "CCME," changed "may" to "will," and added the word "all"; added statement on post-payment reviews and follow-up; deleted examples of review topics.
	Section 8.0	Moved to Attachment A, reorganized, and renamed "Claims-Related Information."
	Section 9.0	Renumbered to Section 8.0.

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Attachment A: Claims-Related Information~~Billing Guidelines~~

Reimbursement requires compliance with all Medicaid guidelines, including appropriate referrals for recipients enrolled in Medicaid managed care programs.

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

Note: Separate CMS-1500 claim forms/837P transactions must be filed for assessment/evaluation and treatment services, and for each type of service provided. Because individual and group speech therapy are considered the same type of service, they can be listed on the same claim form.

Please refer to specific clinical coverage policies for each area. Policies are linked from DMA's Web site at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

~~Outpatient therapy services delivered in accordance with the policy guidelines in Section 5.0 may be submitted for reimbursement.~~

~~Claims for hospital and home health services are filed on a UB-92 or UB-04 form.~~

~~Claims submitted for services provided to a child who has had a CDSA or CDSA-approved evaluation and is therefore eligible for a six-month exemption from prior approval should follow the guidelines listed below:~~

~~Providers who bill on the CMS-1500 claim form (HCFA-1500) must enter the date of the physician's order for services in block 15. Providers who bill on the UB-92 or UB-04 claim form use either form locator 32, 33, 34 or 35 and enter the date of the physician's order for services in the date block and the number "28" in the code block.~~ ~~**Do not change the date once it is entered on the claim form.**~~ ~~If the date is not included on the claim, the service is subject to the same prior approval requirements as those for the six unmanaged visits. Changes cannot be made from the six-visit path to the six-month path.~~

~~Refer to the ***Basic Medicaid Billing Guide*** for additional billing information.~~

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity. Providers who bill on the CMS-1500 claim form must include one of the discipline-specific ICD-9-CM diagnosis codes listed below as a secondary diagnosis on the claim.

V57.0	Respiratory Therapy
V57.1	Physical Therapy
V57.21	Occupational Therapy
V57.3	Speech Therapy

This does not change the requirement to bill the primary diagnosis that justifies the need for the specialized therapy. Remember: The primary treatment ICD–9-CM diagnosis code must be entered first on the claim form. The discipline-specific V code should follow the primary treatment code.

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C. Procedure Codes

Providers must use program-specific codes.

D. Modifiers

Providers are required to follow applicable program-specific modifier guidelines.

E. Billing Units

Follow applicable guidelines.

F. Place of Service

Any outpatient setting allowed by the provider's type and specialty

G. Co-Payments

Follow program-specific guidelines, if applicable.

H. Unit Limitations

Follow program-specific guidelines, if applicable.

I. Reimbursement

Providers must bill their usual and customary charges.